Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Johnson, a prisoner at HMP Holme House, on 15 February 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Raymond Johnson died of lung cancer on 15 February 2020 at HMP Holme House. He was 77 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Johnson received at Holme House was responsive and equivalent to the care which he could have expected to receive in the wider community.

5. We identified two non-clinical issue of concern about the use of restraints when Mr Johnson travelled to hospital.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and record the decision-making process for the risk assessments, including that they fully take into account a prisoner's health and are based on the actual risk a prisoner presents at the time.

- The Governor should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Johnson's clinical care at HMP Holme House.

7. The PPO has investigated non-clinical issues, including Mr Johnson's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. Our family liaison officer contacted Mr Johnson's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Previous deaths at HMP Holme House

10. Mr Johnson was the 13th prisoner to die at Holme House since February 2018. Of those deaths, seven were from natural causes, one was unascertained, two were drug-related and a further two were self-inflicted. Since Mr Johnson died, there have been five more deaths at Holme House, all of which were from natural causes. There are no similarities between our findings in the investigation of Mr Johnson's death and those of the previous deaths.

Key Events

11. On 2 September 2019, Mr Raymond Johnson was remanded in custody to HMP Durham, charged with sexual offences. On 4 October 2019, he was sentenced to nine years in prison and remained at Durham.

12. Mr Johnson had several chronic health conditions including, chronic obstructive pulmonary disease (COPD), high blood pressure and peripheral vascular disease (PVD, a condition where a build-up of fatty deposits in the arteries restricts blood supply to the leg muscles). He used a walking stick and sometimes a wheelchair.

13. On 24 October, Mr Johnson was transferred from Durham to HMP Northumberland. At his initial health screen, healthcare staff requested a routine X-ray. This was completed on 6 November in the prison's healthcare centre and showed changes to his right lung. A prison GP suspected cancer and requested an urgent CT scan which Mr Johnson had on 2 December.

14. On 10 December, Mr Johnson complained of chest pain. An ambulance was called and took him to hospital. Two officers escorted him and, on his way, he was restrained with an escort chain. On the same day, an order was put in place not to resuscitate him.

15. On 12 December, Mr Johnson was diagnosed with lung cancer and the next day, he was moved from hospital to HMP Holme House.

16. Mr Johnson wanted to stay at Holme House so prison staff did not apply for him to be considered for early release on compassionate grounds. Holme House maintained good communication with Mr Johnson's family and arranged regular prison visits for them as his health declined.

17. On the afternoon of 25 December, Mr Johnson choked on his food. Later that day, he complained of shortness of breath and excess oral secretions. Mr Johnson was sent to hospital by ambulance but returned to Holme House that evening.

18. On 30 January 2020, Mr Johnson was diagnosed with a chest infection, for which a prison GP prescribed medication.

19. Mr Johnson died at Holme House on 15 February.

Cause of death

20. A doctor established that Mr Johnson died from lung cancer. The Coroner accepted the cause of death and there was no post-mortem examination.

Clinical Findings

21. The independent clinical reviewer concluded that the care that Mr Johnson received at both Northumberland and Holme House was responsive and equivalent to the care which he could have expected to receive in the wider community. We did not find any clinical issues of concern.

Non-clinical Findings

Restraints, security and escorts

22. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers a prisoner's health and mobility.

23. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and reviewed as circumstances change. The judgement found that using handcuffs or other restraints on terminally or seriously ill prisoners was inhumane, unless justified by security considerations.

24. On 10 December, when Mr Johnson went to hospital, staff completed a person escort record, which showed that an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was applied in line with the risk assessment. However, Holme House provided neither a risk assessment for this journey nor the bedwatch log from 10 to 13 December. We are concerned that there is no evidence of the decision-making process available and no records to confirm whether or not Mr Johnson was restrained during that period.

25. On 25 December, when Mr Johnson went to hospital, staff completed a prison escort record, which was stamped: "TO BE HANDCUFFED AT ALL TIMES NOT FOR RELEASE AS PER RISK ASSESSMENT." But on the next page, the form is marked: "no cuffs". Again, Holme House was unable to provide the risk assessment for this journey and we cannot conclude whether or not he was restrained.

26. We are concerned that in December, Mr Johnson was a Category C prisoner, elderly, had poor mobility and a serious lung condition. Additionally, when he travelled on 25 December, his cancer was terminal. Although the evidence is contradictory about whether Mr Johnson was restrained on that occasion, there is no evidence that Holme House considered his age, mobility, poor health or risk to the public when deciding whether or not to restrain him. We recommend:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and record the decision-making process for the risk assessments, including that they fully take into account a prisoner's health and are based on the actual risk a prisoner presents at the time.

Failure to provide prison documents

27. The Prisons and Probation Ombudsman has unfettered access to relevant documents during investigations and PSI 58/2010, *Prisons and Probation Ombudsman,* makes it clear that prisons must provide the information the Ombudsman's investigator requests as part of her investigation.

28. Holme House was unable to provide the risk assessment and bedwatch records for Mr Johnson's hospital journey and stay in early December, nor the risk assessment for his trip to hospital on 25 December. The guidance for prisons on the handling of records is in PSI 35/2014 on the archiving, retention and disposal of records. It says that the handling of records should be overseen by a Local Information Manager who should ensure that "records are clearly labelled and organised and can be retrieved quickly when required". This was not the case and meant that we were unable to determine whether Mr Johnson had been restrained between 10 and 13 and on 25 December. We make the following recommendation:

The Governor should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation.

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